STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005093	A. BUILDING: _____ B. WING _____	10/01/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WITHAM HEALTH SERVICES	2605 N LEBANON ST LEBANON, IN 46052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This visit was for a State hospital complaint investigation. Complaint: #IN00149919 Substantiated: No deficiencies related to the allegations are cited. Facility Number: 005093 Survey Date: 09/29-10/01/2014 Surveyor: Saundra Nolfi, RN Public Health Nurse Surveyor Witham Health Services is in compliance with 410 IAC 15-1.6-5, Psychiatric Services, Hospital Licensure Rules. QA: claughlin 11/14/14	S 000		